CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR TEMPORARY PODIATRIST LICENSE

INSTRUCTIONS

A temporary license may be issued to an out-of-state Podiatrist who will be taking charge of a Delaware-licensed Podiatrist's practice during the Delaware licensee's temporary illness or absence from Delaware. Temporary licenses are valid for up to three months from date of issuance.

If you need licensure for a Delaware residency program, see the licensure requirements for Podiatrist-In-Training.

Requirements

☐ Submit completed, signed and notarized *Application for Temporary Podiatrist License*.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for the Board office to receive verification of licensure from each jurisdiction (state, U.S. territory or District of Columbia) where you currently hold, or have *ever* held, a license to practice podiatry, sent directly from the jurisdiction to the Board office.

☐ Enclose notarized *Delaware Podiatric Physician's Request Form* completed and signed by the physician whose practice you will be taking charge of. This form is included with the application.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

IDENTIFYING AND CONTACT INFORMATION

1. Name: _____ _____ _____
Last/Family First Middle

2. Other Names Used: None ☐ _____ _____ _____

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Address: _____
Street

_____ _____ _____
City State Zip Code

6. Day Phone: _____ Email: _____ None ☐

EDUCATION AND EXAMINATIONS

7. Enter the following information about the institution where you received your DPM:

   Name: _____ Date of Degree: _____

   Address: _____

8. Enter the following information about your residency:

   Hospital Name: _____

   Address: _____

   Director: _____ Attendance Dates: _____ _____
   From To

9. Enter the requested information about your exams:

EXAMINATION	SCORE	EXAM DATE
APMLE Part I		
APMLE Part II		
APMLE Part III		

LICENSURE AND PRACTICE HISTORY

10. Have you ever been granted a podiatric license by any jurisdiction (state, U.S. territory or D.C.)? Yes ☐ No ☐ If yes, complete the following for all licenses. Use a separate sheet if necessary.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (current or expired)

Arrange for the Board office to receive a license verification from *each* jurisdiction listed above, sent *directly* from the jurisdiction to the Board office.

11. Have you ever held any other healthcare license? Yes ☐ No ☐ If yes, enter this information about *each* license:

TYPE OF LICENSE	JURISDICTION	HAS THIS LICENSE BEEN DISCIPLINED?	IF DISCIPLINED, EXPLAIN:
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	

12. Enter the following information about the locations and dates of your practice. *Include military service.*

EMPLOYER/ PRACTICE NAME	ADDRESS WHERE PRACTICED	NATURE OF PRACTICE	EMPLOYMENT DATES

DISCLOSURES

13. Have you ever been *denied* a podiatric or other healthcare license by any jurisdiction? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Include the license type, jurisdiction, and the reason for each denial.**

14. Have you received any administrative penalties regarding your practice of podiatry in any jurisdictions – such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations – or have you been a party to a consent agreement containing conditions placed by a board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

15. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

16. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

17. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

18. Are any charges or complaints pending against you in any jurisdiction, or are you currently under investigation for unprofessional conduct, professional misconduct, or malpractice? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

19. Have you ever been denied a narcotic license (controlled substance registration) or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

20. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes ☐ No ☐ **If yes, explain fully on a separate sheet. Provide copies of all relevant documents**.

21. Have you ever:
    - Engaged in the practice of podiatric medicine without a license? Yes ☐ No ☐
    - Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes ☐ No ☐
    - Impersonated another person holding a podiatric license? Yes ☐ No ☐
    - Allowed another person to use your podiatric license? Yes ☐ No ☐
    - Aided or abetted anyone not licensed as a podiatrist to represent him or herself as a podiatrist? Yes ☐ No ☐

    If yes to any of the above, explain fully on a separate sheet. Provide copies of all relevant documents.

22. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

23. Are you now, or within the last three years have you been, dependent upon the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

24. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper**.

25. Are you currently physically and mentally *capable* of practicing podiatric medicine and surgery according to generally accepted standards? Yes ☐ No ☐ If no, continue with the next question. If yes, skip to the **DUTY TO REPORT** section.

26. Do you agree to submit to an examination to determine such capability as the Board may deem necessary? Yes ☐ No ☐

DUTY TO REPORT

27. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

28. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

29. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your podiatrist license in another jurisdiction has been subject to discipline or has been surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C.* §515 (a)(9) and that I understand my *duty to self report*.
    Yes ☐ No ☐

    To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

This section to be completed in the presence of a notary public.

SIGNATURE: _____ Date: _____

State of _____ County of _____

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this _____ day of _____, 2_____

Signature of Notary Public: _____

SEAL

My commission expires on _____

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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DELAWARE PODIATRIC PHYSICIAN'S REQUEST FORM

The Delaware podiatrist who needs the services of an applicant for a Temporary License completes and signs this form in the presence of the notary.

1. Name of Applicant for Temporary Licensure: _____

2. Name of Delaware-Licensed Podiatrist: _____

3. Delaware License Number: **E1 -** _____

4. Practice Name: _____

5. Location of Practice: _____
Street

_____ DE _____
City State Zip Code

6. Day Phone: _____ Email: _____

7. When will the applicant be in charge of this practice? From: _____ To: _____
month/day/year month/day/year

8. What is your reason for leaving the practice in charge of the applicant (e.g., illness, leave of absence)? _____

_____

AFFIDAVIT

This section to be completed in the presence of a notary public.

I request that the Delaware Board of Podiatry grant temporary licensure to the applicant named above for the purpose of taking charge of my practice during my absence.

SIGNATURE OF DELAWARE PODIATRIST*:* _____ Date: _____

State of _____ County of _____

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this _____ day of _____, 2_____

Signature of Notary Public: _____

SEAL

My commission expires on _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 9/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 9/2017